Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Pharmacy Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 800-454-3730
PA Pharmacy Fax 8844-512-8999

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328

ADHD PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

MEMBER INFORMATION

Name:	Medicaid ID:
Date of Birth:	Gender:

PRESCRIBER INFORMATION

Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests.
2. Complete **Section III** if this request requires a **peer-to-peer review**.
3. Complete **Section IV** if this request is a **renewal.**
4. Complete **Section V** if the requested medication is also a **non-preferred medication** on the Kansas Medicaid PDL.
5. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Name of medication requested: _____

NDC	Strength	Dosage Form	Quantity	Directions for Use

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section IV

PROVIDER TYPE/DIAGNOSIS:

2. Is the patient ≤ 3 years of age? ☐ YES ☐ NO – skip to question 3.
   - A. Document the prescribing physician's specialty.
     - ☐ Child/Adolescent Psychiatrist ☐ Pediatric Neurologist ☐ Developmental-Behavioral Pediatrician ☐ Other
       - I. If other: Has the prescribing provider consulted with one of the provider specialties listed above in question 2.A.?
         - ☐ YES – If YES, please document the provider's name, specialty and date of consult:
           Provider Name: _____ Specialty: _____ Date of Consult: _____
         - ☐ NO
3. Is the patient ≥ 18 years of age? ☐ YES ☐ NO – skip to question 4.
   - A. Is the prescribing physician a psychiatrist? ☐ YES ☐ NO
     - I. If NO: What is the patient's documented diagnosis (within the previous 365 days) for this request?
       ☐ ADHD ☐ Binge Eating Disorder ☐ Cancer-Related Fatigue ☐ Depression in accordance with DSM-V
       ☐ Hyper somnolence ☐ Narcolepsy ☐ Other – Specify: _____
   - B. Does patient have a documented substance abuse diagnosis (within the previous 365 days)? ☐ YES ☐ NO
     - If YES, written peer-to-peer review is required. Please complete Section III.

PATIENT NAME:		MEDICAID ID:	

SECTION II (CONT.): CLINICAL INFORMATION – For ALL Requests

DOSING LIMITS:

4. Does the dose prescribed exceed the maximum daily dosing limit defined in Table 1 (page 3)? ☐ YES ☐ NO
   - If **YES**, written peer-to-peer review is required. **Please complete Section III.**

SECTION III: PEER-TO-PEER REVIEW

PLEASE NOTE:

- A written peer-to-peer review will be followed by a verbal peer-to-peer review with a health plan psychiatrist, medical director, or pharmacy director for approval if the written request is not approved.

(Provide any/all clinical rationale/justification for this request (i.e. documentation, chart notes, prior therapy, etc.)

☐ PEER-TO-PEER WRITTEN:

_____

_____

_____

_____

_____

☐ PEER-TO-PEER VERBAL

SECTION IV: RENEWAL CRITERIA

1. Is the patient stable? ☐ YES ☐ NO
2. Has the patient been seen by the prescribing provider within the past year? ☐ YES ☐ NO

SECTION V: NON-PREFERRED MEDICATION

Check the appropriate box and provide the required information for consideration of approval of the requested non-preferred medication.

☐ If there is <u>one</u> preferred agent in the preferred category, has the patient experienced an inadequate response after a trial of the preferred agent at a maximum tolerated dose, or do they have a documented intolerance or contraindication to the preferred agent?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

☐ If there are <u>two or more</u> agents in the preferred category, has the patient experienced an inadequate response after a trial of two or more of the preferred agents at their maximum tolerated dose, or do they have a documented intolerance or contraindication to two or more preferred agents?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

List previous medication trial and date(s) of trial:

- Medication Name: _____ Date(s) of trial: _____
- Medication Name: _____ Date(s) of trial: _____

List medication intolerance or contraindication (if any):

_____

_____

☐ An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need

- For formulation requests, please refer to the Non-Preferred PDL PA criteria to ensure specific requirements for oral, non-solid dosage forms are met (http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf)

_____

_____

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

TABLE 1. ADHD MEDICATIONS DOSING LIMITS

Drug	Maximum Daily Dose
Amphetamine (Dyanavel®)	20mg
Amphetamine (Adzenys ER®, Adzenys XR-ODT®)	18.8 mg
Amphetamine (Evekeo®)	40 mg
Amphetamine/Dextroamphetamine (Adderall®)	60mg
Amphetamine/Dextroamphetamine (Adderall XR)	60mg
Amphetamine/Dextroamphetamine (Mydayis®)	50 mg
Atomoxetine (Strattera®)	100mg
Clonidine HCl	0.4mg
Clonidine HCl ER (Kapvay®)	0.4mg
Dexmethylphenidate HCl ER (Focalin XR®)	50mg
Dexmethylphenidate HCl (Focalin®)	20mg
Dextroamphetamine Sulfate (Dexedrine®, DextroStat®, ProCentra®, Zenzedi®)	60mg
Guanfacine HCl (Tenex®)	4mg
Guanfacine HCl ER (Intuniv®)	7mg
Lisdexamfetamine Dimesylate (Vyvanse®)	70mg
Methamphetamine HCl (Desoxyn®)	25mg
Methylphenidate (Cotempla XR-ODT®)	51.8 mg
Methylphenidate HCl (Methylin®, Ritalin®)	100mg
Mehtylphenidate HCl (Jornay PM™)	100 mg
Methylphenidate HCl ER (Aptensio XR®,Metadate CD®, Metadate ER®, QuilliChew ER, Quillivant XR®, Ritalin LA®)	100mg
Methylphenidate HCl ER (Concerta®)	108mg
Methylphenidate HCl ER (Relexxii™)	72 mg
Methylphenidate Transdermal (Daytrana®)	30mg/9hr/day